

# PRIMERICA LIFE INSURANCE COMPANY

EXECUTIVE OFFICE: 3120 Breckinridge Boulevard • Duluth, Georgia 30099-0001 • (770) 381-1000

## PART 1 - MEDICAL HISTORY

LICENSED AGENT NAME (PRINT)

SOLUTION #

DRIVERS LICENSE NUMBER / STATE

POLICY NUMBER

PROPOSED INSURED OR ANNUITANT (PRINT)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

<p>1. a. Name and address of your personal physician? _____</p> <p>b. Date and reason last consulted? _____</p> <p>c. What treatment was given or medication prescribed? _____</p>																									
<p>2. In the past <b>10 years</b> have you been treated for or had any indication of:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 5%; text-align: center;">Yes</th> <th style="width: 15%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>a. Chest pain, angina, heart murmur, heart attack, stroke, or other disorders of the heart or blood vessels?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Nervous or mental disorders, epilepsy or paralysis?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Diabetes or elevated sugar in blood or urine?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Alcoholism or alcohol abuse?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. Drug dependency involving narcotics, depressants, stimulants, hallucinogenics or marijuana?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. Disorders of the skin or lymph glands, thyroid, endocrine system, unexplained fevers, cysts, tumors or cancers?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>g. Syphilis, gonorrhoea or genital herpes?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	a. Chest pain, angina, heart murmur, heart attack, stroke, or other disorders of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	b. Nervous or mental disorders, epilepsy or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	c. Diabetes or elevated sugar in blood or urine?	<input type="checkbox"/>	<input type="checkbox"/>	d. Alcoholism or alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>	e. Drug dependency involving narcotics, depressants, stimulants, hallucinogenics or marijuana?	<input type="checkbox"/>	<input type="checkbox"/>	f. Disorders of the skin or lymph glands, thyroid, endocrine system, unexplained fevers, cysts, tumors or cancers?	<input type="checkbox"/>	<input type="checkbox"/>	g. Syphilis, gonorrhoea or genital herpes?	<input type="checkbox"/>	<input type="checkbox"/>	<p>DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER AND CIRCLE APPLICABLE ITEMS): For questions 2 through 6, include diagnosis, dates, duration and <b>full</b> names, addresses and telephone numbers of all attending physicians and medical facilities. For question 7, list each name, relationship, condition, and age at death (if applicable).</p>
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<p>3. In the past <b>10 years</b> have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or immune deficiency related disorders?</p> <p style="text-align: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>																									
<p>4. In the past <b>5 years</b> have you been treated for or had any indication of:</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>a. High blood pressure, anemia or disorder of the blood?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Ulcer or disorder of stomach, intestines, liver or pancreas?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Disorder of kidney, bladder, prostate or reproductive organs?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Asthma, bronchitis, emphysema, tuberculosis or any other disorder of the lungs or respiratory system?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. Arthritis or disorder of the muscles or bones, including the back, spine or joints?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>	a. High blood pressure, anemia or disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	b. Ulcer or disorder of stomach, intestines, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	c. Disorder of kidney, bladder, prostate or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>	d. Asthma, bronchitis, emphysema, tuberculosis or any other disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	e. Arthritis or disorder of the muscles or bones, including the back, spine or joints?	<input type="checkbox"/>	<input type="checkbox"/>										
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<p>5. Are you now under observation or receiving treatment for any mental, physical or nervous condition?</p> <p style="text-align: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>																									
<p>6. Other than above, have you within the last <b>3 years</b>:</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>a. Had any checkup or examination, or been a patient in a hospital, clinic or sanitarium?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Had any electrocardiogram, x-ray or diagnostic test?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Been advised to have any diagnostic test, hospitalization, or surgery which has not yet been done?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>	a. Had any checkup or examination, or been a patient in a hospital, clinic or sanitarium?	<input type="checkbox"/>	<input type="checkbox"/>	b. Had any electrocardiogram, x-ray or diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	c. Been advised to have any diagnostic test, hospitalization, or surgery which has not yet been done?	<input type="checkbox"/>	<input type="checkbox"/>																
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<p>7. Has any Family Member (parents, brothers, sisters) ever had, or do they have, or have they died from: tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease?</p> <p style="text-align: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>																									
<p>8. In the past <b>3 years</b> have you been postponed, rated or declined for life, health, accident, or sickness insurance?</p> <p style="text-align: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>																									
<p>9. Do you smoke cigarettes now? If yes, how long? _____ years; number of packs per day? _____</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>																								
<p>10. a. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?</p> <p style="text-align: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>b. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability?</p> <p style="text-align: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>																									
<p>11. Females only: Have you ever had any disorder of menstruation, pregnancy or of the female organs or the breasts?</p> <p style="text-align: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>																									

I HEREBY DECLARE that to the best of my knowledge and belief, the statements and answers in this Application are full, complete, and true. These statements and answers are to be considered as the basis for any insurance written hereon. Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

City and State

X \_\_\_\_\_ X \_\_\_\_\_

Signature of Witness

Signature of Proposed Insured

**PART 2 - EXAMINATION REPORT**

Height (in Shoes)	Weight (Clothed)	Males Only:		
		Chest (full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
ft. in.	lbs	in.	in.	in.

Did you weigh?  Yes  No      Did you measure?  Yes  No  
 Is appearance unhealthy or older than stated age?  Yes  No

Details of "Yes" answers. (identify item.)

Blood Pressure (Record ALL readings at rest)

Systolic	4th phase		
Diastolic	5th phase		

	At Rest	After Exercise	3 Minutes Later
Pulse Rate			
Irregularities per minute			

Heart: is there any:

Enlargement  Yes  No      Dyspnea  Yes  No  
 Murmur(s)  Yes  No      Edema  Yes  No

(Describe below - if more than one, describe separately)

Location

--	--

Locate:

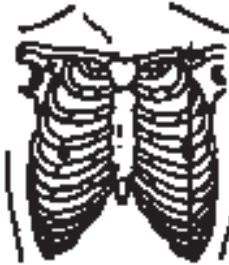
- Constant
- Inconstant
- Transmitted
- Localized
- Systolic
- Presystolic
- Diastolic
- Soft (Gr. 1-2)
- Mod. (Gr. 3-4)
- Loud (Gr. 5-6)

apex by

area of murmur   
by outline

point of greatest   
intensity by

transmission by



For comments and your impression:

After exercise:

- Increased
- Absent
- Unchanged
- Decreased

Is there on examination any abnormality of the following:  
(Circle applicable items and give details.)

Yes No

- (a) Eyes, ears, nose, mouth, pharynx?    
(If vision or hearing is markedly impaired, indicate degree and correction)
- (b) Skin (include scars), lymph nodes, varicose veins or peripheral arteries
- (c) Nervous system (include reflexes, gait, paralysis)?
- (d) Respiratory system?
- (e) Abdomen (include scars)?
- (f) Genitourinary system (include prostate)?
- (g) Endocrine system (include thyroid and breasts)?
- (h) Musculoskeletal system (include spine, joints, amputations, deformities)?
- (i) Are there any hernias or hemorrhoids?
- (j) Are you aware of additional medical history?    
(A confidential report may be sent to the Medical Director)

**\*ANALYSIS OF URINE**

Specific Gravity	Albumin		Sugar	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Are you sure specimen is authentic? Yes  No   
 Are you forwarding this specimen to the Lab? Yes  No

\* Please consult our published guidelines for face amounts needing urine. Send urine if there is history of urinary tract disease, albumin, sugar or if current blood pressure exceeds 140/90.

Date \_\_\_\_\_ Time \_\_\_\_\_ A.M.  
P.M.

X \_\_\_\_\_  
Signature of Examiner

Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_